APPLICATION FOR RESIDENTIAL OR WRAPAROUND SERVICES

By completing this application I understand that its contents may be shared with agencies involved in wraparound services. I have completed & attached the multiagency release of information for this purpose.

DATE OF REFERRAL _____ **COMPLETED BY:** _____
(Signature)

NAME OF PERSON MAKING REFERRAL: _____
AGENCY NAME & ADDRESS: _____
TELEPHONE NUMBER: _____ **FAX NUMBER:** _____
NAME OF DESIRED FACILITY FOR PLACEMENT
****

Please indicate "N/A" or "Unknown" throughout this form as applicable
CLIENT'S NAME: _____ **DOB:** _____ **AGE:** _____

PLACE OF BIRTH: _____ **HEIGHT:** _____ **WEIGHT:** _____

SSN: _____ **GENDER:** _____

RACE: _____ **RELIGION:**

CULTURE: (customs, traditions, heritage, ancestry, etc.)

CURRENT RESIDENCE OF YOUTH: _____
ADDRESS & PHONE #: _____

MEDICAID ELIGIBLE: YES { } NO { } UNKNOWN { } SSI ELIGIBLE: YES { } NO { } UNKNOWN { }

MEDICAID (MA) #: _____ **COUNTY ISSUING MA#:** _____

THIRD PARTY INSURANCE COMPANY NAME, ADDRESS, PHONE NUMBER: _____
_____
POLICY HOLDER'S NAME: _____
ADDRESS: _____ **PHONE NUMBER:** _____

<u>FAMILY ORIGIN</u>:

FATHER'S NAME: _____ **AGE:** _
ADDRESS: _____ **PHONE #: (W)** _____
(H) _____
LEVEL OF EDUCATION: _____ **EMPLOYED: { } YES { } NO**
OCCUPATION: _____ **RACE:** _____
BIRTH DATE: _____ **RELIGION:** _____
MARITIAL STATUS: _____

MOTHER'S NAME: _____ **AGE:** _____
ADDRESS: _____ **PHONE #: (W)** _____
(H) _____
LEVEL OF EDUCATION: _____ **EMPLOYED: { } YES { } NO**
OCCUPATION: _____ **RACE:**
BIRTH DATE: _____ **RELIGION:**
MARITAL STATUS: _____

SIBLINGS:

NAME	SEX	AGE	ADDRESS	RELATIONSHIP
OTHER SIGNIFICANT PEOPLE IN YOUTH'S LIFE (peers, church, extended family, neighbors, etc.)				

DOES EITHER PARENT CURRENTLY HAVE A SIGNIFICANT OTHER LIVING WITH HIM/HER? IF YES, PLEASE SPECIFY WHICH PARENT, AND IF THE SIGNIFICANT OTHER HAS YOUTH LIVING WITH HIM/HER IN THE HOME:

DESCRIPTION OF FAMILY STRENGTHS (accomplishments, coping skills, etc.):

FAMILY HISTORY (Divorce, history of physical, verbal, emotional, or sexual abuse or neglect, domestic violence, family dynamics, etc.):

CUSTODIAL AGENCY: COURT ORDER DATE:
PROBATION OFFICER: PHONE NUMBER:
LEGAL CUSTODIAN NAME: PHONE NUMBER:
FAX NUMBER:
ADDRESS:
TRIBAL AFFILIATION: ENROLLMENT #:
IF NOT ENROLLED, IS CHILD ENROLLABLE? WITH WHICH TRIBE?
COUNTY OF FINANCIAL RESPONSIBILITY:
ADDRESS:
CONTACT PERSON: PHONE NUMBER:
DESCRIPTION OF YOUTH STRENGTHS (spiritual, special interests, hobbies, talents, etc.):

REASON FOR REFERRAL, including current symptoms, severity and nature of all preceding and current behaviors:

BRIEF DESCRIPTION OF PRESENT INDIVIDUAL AND GROUP THERAPY/CASE AIDE:

DATES	FREQUENCY	FACILITY	OUTCOME

BRIEF DESCRIPTION OF FAMILY THERAPY/ INTENSIVE IN HOME/RESPITE/PARENT AIDE:

DATES	FREQUENCY	FACILITY	OUTCOME

MOST RECENT DIAGNOSIS:
(INCLUDE SOURCE AND DATE:)

AXIS I: _____

_____

_____

_____

AXIS II: _____

AXIS III: _____

AXIS IV:

Problems with primary support group, *Specify*:_____
Problems related to the social environment, *Specify*:_____
Educational problems *Specify*: _____
Occupational problems *Specify:*_____
Housing problems *Specify*: _____
Economic problems *Specify*: _____
Problems with access to Health Care Services *Specify*: _____
Problems related to interaction with the legal system *Specify*:_____
Other psychosocial and environmental problems *Specify*:_____

AXIS V: (GAF) _____

FOR WRAPAROUND SERVICES PLEASE ATTACH WRITTEN DOCUMENTATION OF CHILD'S DIAGNOSIS AND GAF SCORE FROM A QUALIFIED MENTAL HEALTH PROFESSIONAL FROM WITHIN THE LAST YEAR.

PAST PLACEMENTS: (most current first) Family/therapeutic foster home, RTC, RCCF, Inpatient, relative care

PROVIDER NAME/ ADDRESS	ENTRY DATE	REASON FOR PLACEMENT	TX PLAN COMPLETED?	D/C DATE	OUTCOME

HISTORY OF YOUTH'S BEHAVIOR:

1. **DESTRUCTIVENESS (include fire-setting):**

2. **AGGRESSIVENESS/SEXUAL OFFENDING:**

3. **SOCIAL STRENGTHS AND NEEDS:**

4. **RELATIONSHIP WITH PEERS:**

5. **RELATIONSHIP WITH ADULTS:**

6. **RELATIONSHIP WITH AUTHORITY:**

7. **VIOLENCE TO SELF/PIERCING/TATTOOS:**

8. **VIOLENCE TO OTHERS (include animals):**

9. **EATING AND SLEEPING HABITS (eating and sleeping disorder symptoms):**

10. **SUICIDE ATTEMPTS/IDEATION (YOUTH):**

11. **MENTAL ILLNESS HISTORY (family):**

12. HISTORY OF SEXUALITY (sexually active, STD's, pregnancy, etc.):

13. ALCOHOL AND DRUG USAGE, INCLUDING SMOKING, HUFFING (YOUTH) - Treatment?

- **NOTE: For youth ages 14 and above, a release of information must be signed by the youth only for release of drug and alcohol treatment records. Parents/guardians are not able to access the youth's records without signed permission by the youth. Please attach release of information if applicable.**

Parental/Other Family Members - Treatment?

Has client been assessed for Fetal Alcohol Syndrome/Fetal Alcohol Effects? { } Yes ( ) No
If yes, what were the results?

14. LEGAL HISTORY:

15. OTHER:

EDUCATION:

HOME SCHOOL DISTRICT:
SUPERINTENDENT'S NAME:
ADDRESS/PHONE #:

PRESENT GRADE LEVEL:_____ LAST GRADE COMPLETED:_____ GED:
RECEIVING SPECIAL EDUCATION? WHAT NEEDS?

SPECIAL EDUCATION DISTRICT:
ADDRESS/PHONE #:
End of Wraparound application. For other services, please continue.
****

GED WAIVER:_____ VERBAL IQ:_____ PERFORMANCE IQ:_____FULL SCALE IQ:

DATE OF COGNITIVE EVAL: _____ TYPE OF IEP: _____CURRENT ED IEP DATE:
EDUCATIONAL STRENGTHS, INTERESTS, AND ACHIEVEMENTS:

EDUCATIONAL DEVELOPMENT (History of learning / perceptual problems, sensory deficits, dyslexia, etc.):

ATTENDANCE HISTORY (punctuality, approximate number of excused and unexcused absences, etc.):

PEER RELATIONSHIPS (in school):

RELATIONSHIP WITH TEACHERS/COUNSELORS:_____

PAST YEAR AND PRESENT YEAR PERFORMANCE (average grades):_____

INDEPENDENT LIVING SKILLS CURRICULUM (required for youth ages 16 and over residing in foster care):

HAS SCHOOL BEEN INFORMED OF REFERRAL?

YOUTH'S INTEREST/SKILLS IN AREA OF VOCATION/WORK/RECREATION AND LEISURE:_____

SCHOOL PLACEMENT HISTORY:

SCHOOL NAME/ADDRESS	DATE ATTENDED

ABUSE/NEGLECT HISTORY:
VICTIM OF ABUSE **("Subject" = person suspected of causing abuse or neglect)**

TYPE OF ABUSE	KNOWN SUBJECT (NAME)	WHEN AND HOW LONG	ASSESSED	RECOMMENDATIONS

CURRENT CONTACT, IF ANY, WITH KNOWN SUBJECT(S):_____

SUBJECT OF ABUSE: ("Subject" = person suspected of causing abuse or neglect)

TYPE OF ABUSE	RELATIONSHIP OF SUBJECT TO YOUTH	WHEN AND HOW LONG	ASSESSED	RECOMMENDATIONS

MEDICAL HISTORY:

1. **KNOWN MEDICAL PROBLEMS/DISABILITIES/HEAD INJURIES (include allergies: medications, food, insects, etc.):**_____

_____

2. **MEDICATIONS (current):**

Drug Name	Dosage	Purpose	Dates Used	Frequency of checks	Precautions

Medications Within last year:_____

_____

3. **PRENATAL, INFANCY, AND YOUTH DEVELOPMENT (walking, talking, potty trained, etc.):**_____

_____

4. **ADOLESCENT DEVELOPMENT (interpersonal skills, friendships, age of menses, etc.):**_____

_____

5. **IMMUNIZATION RECORD:**

TYPE	DATE	TYPE	DATE

DOCTOR'S NAME	CLINIC/ADDRESS	PHONE #	LAST EXAM
DENTIST:			
OPTOMETRIST:			
FAMILY DOCTOR:			
PSYCHOLOGIST:			
PSYCHIATRIST:			

IS THE FAMILY CURRENTLY INVOLVED IN:

	CONTACT PERSON	PHONE NUMBER
☐ SACRED CHILD		
☐ SCOPE		
☐ PARTNERSHIP		
☐ OTHER WRAPAROUND		

DESCRIBE DEFICITS IN:

Self care:_____

_____

Danger to self/others:_____

_____

Thought Processes:_____

_____

Dysfunctional behavior patterns:_____

_____

Adjustment to family/school/other:_____

_____

CURRENT ASSESSMENT OF RUNAWAY RISK:_____

IF THE YOUTH IS NOT RESIDING IN THE BIOLOGICAL HOME, PLEASE COMPLETE:
NUMBER OF YOUTH IN CURRENT FOSTER HOME, IF APPLICABLE:_____

NAME (first names only)	SEX	AGE	RELATIONSHIP TO FOSTER PARENT(S)

COURT ORDER HISTORY: (Include both custody and Juvenile Court information)
Are there any scheduled or pending court appearances? ___ Yes ____ No
If so, please specify:

COURT TYPE	ORDER TYPE	ORDER DATE	EXPIRATION DATE	ADJUDICATION STATUS

DESCRIBE RESTITUTION:_____
DATES(S):_____ **AMOUNT: $**_____

TERMINATION OF PARENTAL RIGHTS HISTORY:

NAME (include youth and siblings)	PARENTAL STATUS	Voluntary/Involuntary	TERM. DATE

YOUTH'S ENGAGEMENT/INVOLVEMENT IN TREATMENT (referral's perception of youth's cooperation):

FAMILY'S ENGAGEMENT/INVOLVEMENT IN TREATMENT (referral's perception of family's cooperation):

POST-DISCHARGE PLAN:

IF THIS YOUTH IS ACCEPTED , WHAT IS THE PLAN FOLLOWING DISCHARGE?_____

WHEN APPLICABLE, PLEASE COMPLETE THE FOLLOWING INFORMATION:

INCOME RECEIVED BY PERSONS LIVING IN THE CHILD'S HOUSEHOLD:

1. Name: _____ **Income Source:** _____ **Amount: $**_____ **How Often:**
2. Name: _____ **Income Source:** _____ **Amount: $**_____ **How Often:**

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS